California Health Policy and Data Advisory Commission
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Minutes
California Health Policy and Data Advisory Commission
February 15, 2008

The meeting was called to order by Vito Genna, Chair, at approximately 9:30 a.m., at the Hotel Solamar, San Diego. A quorum of half of the members was in attendance.

Present:	**Absent:**
Vito J. Genna, Chairperson	Jerry Royer, MD, MBA
William Brien, MD	Kenneth M. Tiratira, MPA
Marjorie Fine, MD	Sol Lizerbram
Janet Greenfield, RN	Adama Iwu
Corinne Sanchez, Esq.	Josh Valdez, DBA
Sonia Moseley	

CHPDAC Staff: Kathleen Maestas, Acting Executive Director; Terrence Nolan, Office Manager

OSHPD Staff: David M. Carlisle, MD, PhD, Director; Elizabeth Wied, Chief Legal Counsel; Michael Rodrian, Deputy Director, Healthcare Information Division; Patrick Sullivan, Assistant Director, Legislative and Public Affairs; Candace Diamond, Manager, Patient Discharge Data Section; Starla Ledbetter, Data Management Office

Others Present: Susan Huang, MD, MPH, Division of Infectious Disease, University of California, Irvine; Pamela Lane, Vice President, Health Informatics, Chief, California Hospital Association

Chairperson's Report: Vito Genna, Chair

Chairperson Genna stated that Dr. Howard Harris, a fellow Commissioner for many years, resigned from the Commission effective January 2008. Dr. Harris also stepped down as Chairperson of the Health Data and Public Information Committee. Dr. Harris has been supportive, and encouraging, providing a great amount of information to the Commission. He began his service as a Commissioner in 1989 and his contributions to the Commission over the years are substantial. Chairperson Genna stated that he appreciate Dr. Harris' years of service, both in presence and

participation." Dr. Harris will continue his work as a member of the Committee for the Protection of Human Subjects.

Chairperson Genna recounted his recent experience with a serious illness (which was successfully treated) as an illustration of the difficulties that come into play when defining new data elements, not the least of which being the patient's own delay of treatment and admission to a healthcare facility. Chairperson Genna stated that he was seen and treated in numerous locations and different times before being admitted to the hospital which poses numerous questions such as, where in the timeline do you capture the value for temperature; would it be the temperature from the initial contact with his physician in Fresno; would it be the reading taken at the emergency room in San Diego a number of days later; or would it be the reading taken a number of days after that when Chairperson Genna was admitted to a hospital in Fresno? These examples give some idea of the type of decisions that OSHPD staff encounter as they move forward in the definition process for the new data elements.

Approval of Minutes: A motion was made by Commissioner Brien and seconded by Commissioner Greenfield to approve the minutes of the December 7, 2007 meeting. The motion was carried.

The Commission agreed to reschedule the June 27, 2008 CHPDAC meeting to June 9, 2008.

Health Data and Public Information Committee Report: Marjorie Fine, MD, Chair

Commissioner Fine presented an extensive summary of the January 15, 2008 HDPIC meeting to the Commission focusing on the motion passed by the HDPIC regarding the proposal to amend the patient-level data program regulations to add the data element "Principal Language Spoken" and to make one clean-up change. The Office requested that the CHPDAC recommend that the Office adopt the proposed regulatory changes.

Commissioner Fine echoed Chairperson Genna's illustration of the difficulties in defining the sentinel values for new data elements. "At the HDPIC meeting we talked about the delays in the emergency room. Just as Vito's hospital did not have enough beds, people commonly will board in the emergency room for a day, and have their lab values corrected. So by the time they are admitted, the numbers do not reflect how ill they are."

OSHPD Director's Report: David M. Carlisle, MD, PhD, Director, OSHPD

OSHPD Director, Dr. David Carlisle, stated that he wanted to begin by expressing his own appreciation to Dr. Howard Harris. "He has been a member of the Commission for a long time. He will be missed and his service is deeply appreciated."

Director Carlisle stated that the Governor's Healthcare Reform proposal ABX1 1 reached a roadblock in the Senate Health Committee, with one aye vote, and seven nays. The message was a resounding statement that there was an issue with the bill. "I think the bill began to lose momentum, especially just before the vote, when data started to come out of the State of Massachusetts that they were seeing significant cost overruns,

especially with the government purchasing pool portion of their health insurance proposal, which basically was used as a model for the California proposal."

"I don't recall a time when we have had a coalition of insurance companies, hospitals, and consumer organizations working with the government to try to achieve universal health insurance in the State of California. I think the finance question is really the one salient question that stands between us and the accomplishment of universal health insurance. And if we can solve that, I think we can get there."

At the December meeting, Director Carlisle was asked to make some brief comments regarding the CHPDAC budget. Director Carlisle explained that CHPDAC is funded directly from the Data Fund, and does not have an autonomous budget. The funds that are not expended during the budget year, by the Commission, are returned to the Data Fund. "Our expenditures for CHPDAC have been roughly the same as they have been historically. And, again, the CHPDAC is entirely supported by the Data Fund, so the General Fund issues that pertain to the Department's budget and the overall State budget are not relevant."

Legislative Update: Patrick Sullivan, Assistant Director, Legislative and Public Affairs

The Legislators are in the second part of a two-year session. Their deadline to introduce new bills is not until February 22nd. At this time there have not been any new bills introduced that impact OSHPD.

In January, the Governor issued a fiscal emergency to deal with the $16.5 billion budget deficit. The Fiscal emergency gives the Legislature 45 days to make mid-year cuts. After the 45 day period is up, if they have not come up with these new cuts, the Legislature is supposed to cease working on all the other business of the House and address only the mid-year cuts.

Regarding public affairs activities, OSHPD released the *California Report on Coronary Artery Bypass Graft Surgery, 2005 Hospital Data* report at the beginning of the year. OSHPD had good success in the media with approximately 15 outlets picking it up. In January there was a press release done for the Fair Pricing Program. OSHPD is working with Health Access, and other groups, to try to disseminate that information further out so it reaches the consumers who can use that information to understand more about hospitals' discount payment programs.

Lastly, Charles Ornstein, one of California's best journalists, currently with the LA Times, had requested a meeting with Michael Rodrian and his staff, to go over OSHPD's data collection. The meeting did take place and went very well. Mr. Ornstein was looking for ways to use OSHPD data to support various articles and it was a very positive meeting.

Chairperson Genna stated that he had seen in a number of press releases that Dr. Parker was quoted as saying, "I don't think you can have a complete picture of how California hospitals are doing with heart revascularization procedures until outcomes for both bypasses and PCI are measured." Chairperson Genna asked in what way the Commission could assist in bringing that about.

Director Carlisle stated that had ABX1 1 passed, which did contain the alternative revascularization procedure Percutaneous Coronary Intervention (PCI), the Office would have already been preparing to go forward and add angioplasty procedures to the portfolio of outcomes. The Office has been discussing this for a number of years. Over time angioplasty and PCI have replaced Coronary Artery Bypass Graft Surgery (CABG) as the revascularization procedure of choice when appropriate. "Angioplasty is not appropriate for all patients, and there are some patients that can only be revascularized with the CABG procedure, and who do much better after they have had CABG versus an angioplasty." The Office intends to explore ways to proceed in this direction, examining whether OSHPD has the authority now or whether legislation would be required.

Director Carlisle added, "I should mention that our CABG report, unlike all the other outcome reports that we do, which utilize administrative data, or discharge data, uses medical record data that is abstracted directly form the medical record, and that gives us the highest performance in terms of our risk adjustment model. We think that is important because we are reporting on individual physicians, and surgeons and the results can impact their careers directly. Other states are reporting on PCIs right now, using administrative data sets. ABX1 1 would have called for us to collect clinical data from the medical record in reporting on PCI outcomes, and that would be our preferred course of action."

Commissioner Fine asked, "Who decides the topics the TAC addresses?"

Director Carlisle stated that the Office decides the topics, but that the TAC can recommend topics. Decisions are made on cost, volume and significance of the outcome, specifically mortality.

Chairperson Genna asked if the Commission could make a motion for the Office to study this issue and see what the significance would be regarding PCI.

Director Carlisle indicated that the Commission could entertain a recommendation that the Office examine PCI.

Commissioner Greenfield moved that, "The Commission requests that the Office should more closely look at the addition of Percutaneous Coronary Intervention (PCI) to the outcomes being studied." Commissioner Fine seconded the motion. The motion was passed.

Proposed Regulations: Candace Diamond, Manager, Patient Data Section

Manager Diamond stated that the letter that HDPIC Chairperson Fine submitted to the Commission describes the action the HDPIC took. "The Committee heard and approved our proposal to add principal language spoken to the list of data elements that would be collected on our patient level databases."
Senate Bill 680, by Senator Figueroa, mandated the addition of principal language to the in-patient, ambulatory surgery, and the emergency department data collection programs. Assembly Bill 800 added a requirement that the patient's principal language spoken be

captured in the medical record. This is part of the legislation that added momentum to OSHPD studying this issue and coming up with the current proposal.

40 percent of Californians speak a language other than English which can precipitate numerous challenges in healthcare situations including: questions from patients may be misunderstood; symptoms may be misunderstood or not described in a language that both the patient and provider can understand; there may be inappropriate test ordered; there may be confusion on how to take medications and follow-up appointments may be missed.

Beginning in 2006, OSHPD began looking for an applicable standard. There were many national standards used by a variety of agencies and several models that California State agencies used but no precise one that California or the nation used, so OSHPD ended up with a complicated grid of who uses what, and how many languages, and what purpose each model served.

OSHPD looked at the National Information Standards Organization (NISO) and the International Organization for Standardization (ISO). OSHPD honed in on the best possible model for California and worked very proactively to get it adopted and moved into national standards that are aligned with public health.

OSHPD worked with the Public Health Data Standards Consortium, the National Association of Health Data Organizations (NAHDO), the Federal Agency for Healthcare Research and Quality and various state workgroups. OSHPD presented the model that had been developed to the American National Standards Institute and the Architecture Committee added it to the Healthcare Services Data Reporting Guide as part of the healthcare national standard.

Manager Diamond stated, “It is that set of standards that we have modeled all the emergency department and ambulatory surgery national standards on. We found what we wanted, we got it into a national standard, and we are asking that CHPDAC consider the recommendation from HDPIC and that you move to give us approval of this proposal.”

Commissioner Sanchez noted that Spanish was on the list of 30 languages in the proposal. “There are derivative groups of Latinos, and there are derivative languages of those Latino break-out groups.”

Manager Diamond stated that subcategory “b” is where Mayan, Guatemalan or any other derivative language could be listed. The responsibility will be on providers to capture those languages in detail and not lump everything into a more general category like Spanish, or Chinese.

Commissioner Brien asked for clarification as to how this requirement applies to out-patient clinics or offices licensed under a hospital.
Manager Diamond stated, “All of the outpatient care that is under the hospital’s license does not give us encounters or patient records, only the ambulatory surgery under the

hospital's license, and the emergency department under the hospital's license. So it is those two isolated types of outpatient care that we have the authority to request of."

Commissioner Brien asked that his question and the response be noted in the minutes.

Commissioner Moseley asked for an explanation of some of the ways this information would be used.

Manager Diamond stated that the hope is that this information will be used in a variety of ways. Perhaps it will influence practice; perhaps it will be used in research to see if outcomes are different when there are language differences.

Director Carlisle added that, "There has been research, not using discharge data, but other data collection techniques, that has shown that language variation is actually an outcome risk factor, and that non-English speaking patients do worse in terms of outcomes, after you adjust for all other risk factors."

Commissioner Brien moved to approve the proposed regulation package as presented. Commissioner Moseley seconded the motion. The motion passed unanimously.

Presentation by Health Care Researcher: Susan Huang, MD, PhD, Division of Infectious Diseases, University of California, Irvine

Dr. Huang stated that the purpose of her presentation was to illustrate the potential utility of a new data element, Identification of Transferring Facility. Specifically, this presentation demonstrated how this variable might actually inform the response to emerging infections and emergency planning at the hospital, county and State level.

There are huge numbers of superbugs in the world today. The three most impressive superbugs:

- Methicillin-resistant staph aureus (MRSA)
- Vancomycin-resistant enterococcus (VRE)
- Multi-drug resistant (MDR) Acintobacter

Using MRSA as an example, Dr. Huang explained its rapid trajectory from when it was first noted in the United Kingdom in the late 1960's to the 1980's when the United States began to see a very rapid rise in both people who were colonized with MRSA, as well as people who were infected by it. MRSA is known to cause substantial outbreaks in hospital settings, and in skilled nursing settings. Recently there is a new clone that is occurring in the community.

Staph aureus is a bacterium. In its normal form, which is not resistant, it resides in 30 percent of the population. It does not do much unless given the opportunity to do so, such as a bruise, a cut, or a big surgery that gives it a portal of entry.

Dr. Huang showed the burden estimates done by the Centers for Disease Control (CDC), which showed the hospitalizations due to MRSA had risen from 133,000 in 2000

to 278,200 in 2005 illustrating the huge epidemic spread of MRSA today. This type of information has lead to unprecedented legislative measures in the United States.

There are 14 states that have either passed legislation or have pending legislation related to MRSA. In September 2006, a general bill for looking at healthcare associated with infections was passed. This included language about looking at MRSA in some form. And the recommendation that is going forward is to look at some elements of bacteremia in all hospitals in California.

Dr. Huang stated that the areas to begin addressing this issue are in assessment and intervention. "We would want to start at the areas of highest transmission, for example hospitals. Where do patients go from hospitals or skilled nursing facilities? Where do they go; how do they interact? Is this an issue of inter-facility transfer and inter-facility communication?"

"The current value of OSHPD data is that it tells us a lot about acute patient flow; hospital to hospital. It tells about flow, and if you can understand how many people cross over in a given month, or a given year, you can understand a little bit more about how transmission can occur and what is the speed of that transmission. So it helps us assess speed of the spread, it helps understand exposure of risk from other institutions. OSHPD data can tell us a lot about acute care, but what it does not tell us is about the flow that is being received by these acute care centers from skilled nursing facilities and from rehab centers, which often are a huge reservoir of these resistant organisms. Not because they necessarily generate it themselves, but because acute care hospitals send patients to them, they care for them, and then transfer them back when they become acutely ill."

In summary, there is a great need for tracking infectious diseases. The variable being proposed is to identify the transferring facilities exactly, and not just as a rehab or a skilled nursing facility. This information will complete the picture of flow of patients throughout the State.

Commissioner Brien stated, "This is really clarifying the data that is already in part collected, now you are putting in which SNF, or which rehab center or which hospital. I think that is reasonable."

Deputy Director Rodrian added that this kind of specific information would actually help OSHPD improve some other products; for example, community-acquired pneumonia, where coding has been an issue. This would make the data more specific.

Director Carlisle stated that this was a very interesting proposal. "It would certainly augment a lot of the data we collect, and what others can do with that data. But it requires careful scrutiny and evaluation." Patient identification issues are a complicating factor.

<u>Commissioner Brien made a motion to refer this proposal back to the Director and Staff to look at the various implications and feasibility of adding the "Identification of Transferring Facility" variable and report back to the Commission at some point.</u>

Commissioner Greenfield seconded the motion. Dr. Brien amended the motion to state "by the June meeting" in place of "at some point."
The motion was unanimously passed.

Possible additions to Patient Level Data Sets: Starla Ledbetter, Data Projects Manager

- Status report on project to evaluate clinical and other data elements for possible addition to Patient Level Data Programs
- Reviewed the Office's preliminary definitions for data elements that have been recommended for possible addition to the patient level data programs.

Manager Ledbetter presented the Committee with a handout covering the draft version of the "Data Element Definitions Document." Manager Ledbetter stated that at the beginning of the document there is a section called "General Definitions" which are definitions that apply to all the data elements being considered. For example, "Admission," where "we are talking about time of collection of lab values, you have to define time of admission to determine time of collection." Next in the document are sections entitled "Laboratory Tests (Inpatient)," "Vital Signs (Inpatient)," and "Other Data Elements." Under "Other Data Elements," the Operating Physician and Patient Address are being considered for all three data types: the inpatient, emergency department and ambulatory surgery. Also, Physician ID and Patient Address are in the national standard now and do not count against the 15 new data element limit.

On the draft document all areas are open to comment or suggestion but areas that are italicized are specifically designated as open for comment or suggestion. For example, AST, SGOT, in the "Time of Collection" column, "*first lab test within 24 hours of admission*" as well as, in the "Location" column, "*all inpatients*."

Manager Ledbetter continued with the "Location" column and stated that with "*all inpatients*" OSHPD has to decide whether that means all inpatients or limit it to general acute care. From preliminary discussions with hospitals it has been suggested that it would be easier to report on all inpatients as opposed to picking certain groups or excluding certain groups. This is another area for which staff requests further input.

For the "Units of Measures" column, staff have discovered that conventional units are used more often that international units and staff is currently in the process of identifying which particular measures are used for each of the data elements.

Manager Ledbetter stated that with regard to Prothrombin Time and International Normalized Ratio, staff are looking into which would be the better test measure to capture. The International Normalized Ratio is the standardized variable across the globe therefore that might be the easier test measure to go with. But this is still being looked at by staff.

Another decision staff is investigating is whether to use hemoglobin or hematocrit; should they both be captured or is one better than the other. Some hospitals use Fahrenheit and some use Celsius when reporting temperature. Staff are considering accepting

either one, with the indication which unit of measure was used. Staff would entertain any feedback on either of these issues.

Finally on the last page of the draft document, "Operating Physician" is being considered by staff to ascertain which procedures OSHPD would want to capture the Physician ID. For example, specific procedures or only principal procedures, and how staff would identify the physician: using the National Provider ID; the License number assigned by the Medical Board of California of the Department of Consumer Affairs; first name, middle initial, and last name or a combination those.

Staff are doing on-site visits and based on information OSHPD gets back, the draft document will be revised. Then this will be sent out to all facilities in California so they have a chance to provide feedback. This is all prior to regulations being written. So OSHPD is still in the information gathering phase. Manager Ledbetter stated that at the next CHPDAC meeting staff will present a summary of all the suggestions that have been received regarding the data element definitions.

Report from Health Information Division: Michael Rodrian, Deputy Director

Deputy Director Rodrian stated that the meeting with L.A. Times reporter Charles Ornstein was both interesting and productive. Mr. Ornstein stated that if OSHPD begins to see trends or changes in direction in collected data, those are the things OSHPD should let the news media know about so the media can call attention to those changes.

Commissioner Fine asked if Mr. Ornstein would be willing to do a trends in healthcare column in the healthcare section of the L.A. Times?

Deputy Director Rodrian acknowledged the suggestion and added that Mr. Ornstein also indicated that the information has to be newsworthy.

Commissioner Fine explained that some issues that don't immediately appear to be newsworthy can actually be very pertinent upon closer examination, for example, collecting data on languages. "If you put it the way Candace has presented it, that doctors don't always speak the language of their patients and people get confused about instructions. It is newsworthy that California is doing something because we have a diverse population and because we are trying to improve quality of care and this is one of the ways that we can help our patients in the State."

HDPIC member Pamela Lane added, "Taking that idea of the language one step further, getting the information out there to the public will give hospitals less push-back when you ask the patient what it is you want, because we get a lot of push-back when we ask people their ethnicity and race, because they don't want to answer that question."

Identification of Hospice Patients in the Patient Discharge Data: Candace Diamond, Manager Patient Data Section

Manager Diamond began her presentation with some background information on hospice care including:

- Hospice care is for patients with prognosis of six months or less
- Hospice care are always refers back to the underlying terminal illness
- Hospice care is palliative, comfort care and not curative

Often it is difficult to get hospice care data because the terminal illness is so well documented and that is where the focus and treatment reside. The American Health Information Management Association (AHIMA) has examined some of the medical records challenges, including how do you code, what do you code, why do you code the information that's documented in the medical records? "Is the documentation really there that can be coded? The coder may know things, may see things, may be able to infer things, but coding rules are such that the coders have to live by the coding conventions."

Hospice Settings:

- Hospital Inpatient
    - Acute care
    - Skilled nursing
    - Other bed types
- Specialty Hospital
- Long-term Care Facility
- Hospice Organization
- Home Health Agency
- Home

OSHPD can see some hospice care in all of these settings. It is not really limited to just the fact that it shows that you were discharged to home health, or you were discharged to hospice.

Manager Diamond stated that the Commission had posed the question, "In OSHPD's outcomes studies, do hospitals that provide hospice care see lower quality results due to higher mortality rates?"

The ICD-9 contains a V code (V66.7, in any secondary diagnosis field) that codes for palliative care. This code has not been used in OSHPD outcomes studies. Instead, to take into account whether a patient has expressed a preference to not be resuscitated, OSHPD has used the data item that reports a DNR (do not resuscitate order) was in place for the patient. More detailed analyses have found this to be problematic. Using hospital patient data from 2006 to compare patients that had a DNR order, or a palliative care order, or both, Dr. Tran found that of the 161,902 patient admissions with DNR orders, relatively few (11,344, 7.01%) were also admitted for palliative care. In contrast, of the 20,157 patient admissions for palliative care, over half (11,344, 56.28%) also had a DNR order in place. These patients were very similar in age, race/ethnicity, gender, and source of payment. However, the patients admitted for palliative care (with or without a DNR order in place) were more likely to die in-hospital (54% of P. care patients vs. 16% of DNR patients). This suggests that the V Code for palliative care might be a better indicator that a patient is severely ill, compared with the DNR indicator. Doctor Tran also looked at the top ten diagnoses that are associated with palliative care and found that

those underlying disease look very similar to the patients who had both DNR and palliative care.

Outcomes studies do use underlying terminal illness to control for expected rate of death. For example, there were a number of diseases that excluded patients from the community-acquired pneumonia study. There are a number of way that underlying terminal disease are used to risk adjust. One of the biggest variables OSHPD adjusts for is age. A patient is expected to have a different mortality rate if they are 65 and over, or according to the age cohort that a particular outcome study uses.

In conclusion Manager Diamond stated even though the palliative care code is not currently being used, "with the difficulties we have with the DNR code, the palliative care code certainly something that might give us another tool for risk adjustment."

Report on Contact With Department of Public Health Regarding Pharmacy data Collection Within Their Department: Michael Rodrian, Deputy Director

Deputy Director Rodrian reported that he did meet with staff from the Department of Public Health. Pharmacy data collection is still quite embryonic and has more problems than laboratory reporting. Laboratory reporting has some differences with ranges and definitions but it can be electronically reported and is being addressed in the new data elements. It is too early to look at the electronic reporting of pharmacy data.

Chairperson Genna stated that the question about pharmacy data came up at the last meeting because there are a lot of hospital admissions that are coming in due to three medications: either over-doing; or under-dosing; or a combination of both.

Director Carlisle stated that E-codes may provide insight into medication misadventures, to the extent that they are reported to OSHPD. Staff are just starting to evaluate some E-codes and some of these do describe medication misadventures. But these E-codes fall under voluntary reporting.

Deputy Director Rodrian added that at some point OSHPD may evaluate making the reporting of these voluntary E-codes mandatory.

Next Meeting: The next meeting will be held on April 25, 2008 in Sacramento, California.

Adjournment: The meeting adjourned at 1:25 p.m.

Pending Items:

1. Commissioner Greenfield moved that, "The Commission requests that the Office should more closely look at the addition of Percutaneous Coronary Intervention (PCI) to the outcomes being studied." No timeline stated.

2. Report to the Commission on the implications and feasibility of adding the "Identification of Transferring Facility" variable at the June meeting.

3. Report on summary of suggestions received regarding the data elements definitions.